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No. 02-5664

In the Supreme Court of the United States

CHARLES THOMAS SELL, PETITIONER

v.

UNITED STATES OF AMERICA

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR THE UNITED STATES

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QUESTION PRESENTED

The Court granted certiorari limited to the following question:

Whether the court of appeals erred in rejecting petitioner's argument that allowing the government to administer antipsychotic medication against his will solely to render him competent to stand trial for non-violent offenses would violate his rights under the First, Fifth, and Sixth Amendments.

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OPINIONS BELOW

The opinion of the court of appeals (J.A. 356-382) is reported at 282 F.3d 560. The order of the district court (J.A. 339-355) is unreported. The memorandum and order of the magistrate judge (J.A. 320-338) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on March 7, 2002. A petition for rehearing was denied on May 7, 2002 (J.A. 383). The petition for a writ of certiorari was filed on August 2, 2002, and was granted on November 4, 2002, limited to the question specified by the Court. The jurisdiction of this Court rests on 28 U.S.C. 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The relevant constitutional, statutory, and regulatory provisions are reprinted in an appendix to this brief. App., *infra*, 1a-16a.

STATEMENT

1. On May 16, 1997, petitioner, a dentist, was charged in a complaint with making false representations in connection with payments for health care services, in violation of 18 U.S.C. 1035(a)(2). On May 20, 1997, the government filed a motion pursuant to 18 U.S.C. 4241(a) for a psychiatric examination of petitioner to determine his competence to stand trial. After a hearing, a magistrate judge ordered that petitioner be sent to the U.S. Medical Center for Federal Prisoners at Springfield, Missouri (Springfield), for an evaluation under 18 U.S.C. 4241(b). On July 15, 1997, after receiving a psychological evaluation from Springfield, the magistrate judge ruled that petitioner was competent to stand trial. Petitioner was thereafter released. J.A. 357-358.

On November 6, 1997, a superseding indictment was returned charging petitioner and his wife with 56 counts of mail fraud, in violation of 18 U.S.C. 1341; six counts of Medicaid fraud, in violation of 42 U.S.C. 1320a-7b(a)(1)(i); and one count of money laundering, in violation of 18 U.S.C. 1957(a). J.A. 12-22.

On April 23, 1998, a separate indictment was returned charging petitioner and his wife with conspiring to murder a witness and an FBI agent, in violation of 18 U.S.C. 1114; two counts of attempted murder of a federal witness, in violation of 18 U.S.C. 1512(a) and 1513(a); one count of attempted murder of a federal officer, in violation of 18 U.S.C. 1114; and two counts of soliciting violence, in violation of 18 U.S.C. 373. J.A. 23-29, 358. The indictment alleged that petitioner and his wife solicited a person to kill two individuals: the FBI agent who arrested him, and a former employee at his dental office who had cooperated with law enforcement in its fraud investigation and who planned to testify against petitioner on the fraud charges. *Ibid.* On December 3, 1998, following a plea by petitioner's spouse, a superseding indictment was filed against petitioner in the murder conspiracy case. The

attempted murder and fraud cases were joined together for trial. J.A. 358.[1]

2. In February 1999, petitioner's counsel moved for another hearing to determine petitioner's competency to stand trial, and the government moved to have a government psychologist examine petitioner. After a hearing, a magistrate judge entered an order under 18 U.S.C. 4241(b) that petitioner be sent to Springfield for another competency evaluation. On April 14, 1999, after receiving a psychological evaluation from Springfield, the magistrate judge found by a preponderance of the evidence that petitioner was suffering from a mental disease or defect that rendered him incompetent to stand trial because he was unable to understand the nature and consequences of the proceedings against him or to assist properly in his defense. 18 U.S.C. 4241(d). Petitioner's psychiatrist, Dr. Robert Cloninger, and the government's psychologist, Dr. Richart DeMier, diagnosed petitioner with "delusional disorder, persecutory type." J.A. 359.[2]

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[1] Petitioner was originally released on bond. Following allegations that he attempted to intimidate a witness, his bond was revoked, after a hearing at which petitioner's behavior was out of control. J.A. 358 (petitioner "screamed, shouted, and used racial epithets," and "spit directly" in the magistrate judge's face). Petitioner is currently being detained pending trial (and would be so held even without the order committing him under 18 U.S.C. 4241).

[2] "The essential feature of Delusional Disorder is the presence of one or more nonbizarre delusions that persist for at least 1 month." *Diagnostic and Statistical Manual of Mental Disorders* 297.1, at 296 (4th ed. 2000) (DSM IV). The "bizarreness" of the delusion can distinguish delusional disorder from schizophrenia, a mental disorder involving delusions that "are clearly implausible, not understandable, and not derived from ordinary life experiences." *Ibid.* "In contrast, nonbizarre delusions involve situations that can conceivably occur in real life." *Id.* at 297. The persecutory subtype of delusional disorder applies "when the central theme of the delusion involves the person's belief that he or she is being conspired against, cheated, spied on, followed, poisoned or drugged, maliciously ma-

Pursuant to 18 U.S.C. 4241(d), the magistrate judge ordered that petitioner be hospitalized at Springfield for a reasonable period of time not to exceed four months to determine whether there was a substantial probability in the foreseeable future that he would attain the capacity to stand trial. Upon his return to Springfield, petitioner was under the care of two clinicians, Dr. DeMier, the clinical psychologist, and Dr. James Wolfson, the consulting psychiatrist, who determined that antipsychotic medication was needed in order to render petitioner competent to stand trial. On June 9, 1999, petitioner had an administrative hearing, pursuant to 28 C.F.R. 549.43, before a reviewing psychiatrist, Dr. Charles D. Glazzard, to determine whether petitioner should be involuntarily medicated. J.A. 141-151, 359-361. Dr. Glazzard considered evidence that in 1982 petitioner was diagnosed with schizophrenia following a hospitalization that occurred after he reported a hallucination of a leopard in his office and near a bus. J.A. 146-150, 153. Dr. Glazzard also heard from Dr. DeMier and Dr. Wolfson, who testified that petitioner's "symptoms point[ed] to a diagnosis of Delusional Disorder but also recognize[d] that there well may be an underlying Schizophrenic Process." J.A. 147. Dr. Wolfson believed that "antipsychotic medication [was] indicated" to treat petitioner's psychotic symptoms. *Ibid.*

Petitioner proffered a four-page affidavit of Dr. Cloninger, who stated his view that there was "no evidence that neuroleptics [antipsychotic medications] are beneficial for patients with Delusional Disorder." J.A. 31. Dr. Cloninger opined that "the treatment of [petitioner] should be limited to basic support," including "a safe supportive milieu with access to exercise and reading material," and "voluntary symptomatic treatment" with antidepressants. J.A. 32.

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ligned, harassed, or obstructed in the pursuit of long-term goals." *Id.* at 298.

Following the hearing, Dr. Glazzard concluded that antipsychotic medication was required to restore petitioner's competence to stand trial. J.A. 144-145, 150. Dr. Glazzard also found that other forms of medication or treatment would not alleviate his delusional symptoms. J.A. 151. On July 2, 1999, Sherman Waltner, the Bureau of Prisons reviewing official, denied petitioner's administrative appeal in a written opinion confirming Dr. Glazzard's conclusions. J.A. 152-157. Springfield delayed administration of the medication to give petitioner the opportunity to seek judicial review. J.A. 361.

On September 29, 1999, a magistrate judge conducted an evidentiary hearing to determine whether petitioner should be involuntarily medicated. J.A. 158-319. Dr. DeMier testified that petitioner's condition had deteriorated since June 1999 and would continue to deteriorate if he were not treated with antipsychotic medication. J.A. 165-167, 172. Dr. DeMier stated that the delay in treatment could lengthen the period of necessary treatment and could diminish the optimal response of the treatment. J.A. 165, 216. Based on petitioner's conduct at Springfield and his history, Dr. DeMier believed that petitioner was dangerous. J.A. 172-174.

Dr. DeMier opined that "anti-psychotic medication [was] clearly indicated, as it [was] the only treatment that we could reasonably expect to improve [petitioner's] condition." J.A. 176. He believed that there was not "any other effective method of treating [petitioner's] symptoms at this time," J.A. 177, and that antipsychotic medication was "the only effective means to improve his mental state." J.A. 184. He also believed that petitioner could "be restored to competency, as a result of treatment with anti-psychotic medications." J.A. 176. Dr. DeMier testified that he had been involved in the treatment of two patients with delusional disorder who had been administered antipsychotic medication and that one patient had regained competency and the

other had shown significant improvement. J.A. 174-176, 184-185. Dr. DeMier acknowledged that there were "potentially significant side effects" from the medication, such as tardive dyskinesia (from long-term use) and neuroleptic malignant syndrome (in very rare instances). J.A. 185-188.

Dr. Wolfson, the consulting psychiatrist, agreed that petitioner was psychotic and that Dr. DeMier's diagnosis of delusional disorder was a plausible one, but he did not exclude schizophrenia as an alternative explanation for his symptoms. J.A. 227. Regardless whether petitioner should be diagnosed as schizophrenic or delusional, however, Dr. Wolfson testified that petitioner was "clearly psychotic" and the appropriate course of treatment in either case was medication. J.A. 227, 228.[3] Based on petitioner's conduct at Springfield and his history, Dr. Wolfson believed that petitioner was dangerous in a broadly defined sense. J.A. 232.

Dr. Wolfson testified that he had treated between 1000 and 2000 patients with antipsychotic medication and that most of them had positive results. J.A. 233. He noted that antipsychotic medication had some potential unpleasant side effects, such as dystonic reaction and sedation. J.A. 233-234, 240. Dr. Wolfson stated that such side effects could be mitigated by other medicines or treatments and that "most patients don't have to expect problematic side effects as the cost of having their illness treated and having control of their own thoughts and minds." J.A. 234. Dr. Wolfson testified that neuroleptic malignant syndrome was also a potential serious side effect, which he estimated as occurring

[3] "In DSM-IV, there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders." DSM IV xxii. Appropriate diagnosis and treatment decisions accordingly are not confined to a specific diagnosis. *Id.* at xxiii ("The specific diagnostic criteria included in the DSM-IV are meant to serve as guidelines to be informed by clinical judgment and are not meant to be used in a cookbook fashion.").

in 1 in 10,000 cases, but he noted that "the risk of the continuing illness [was] greater than the risk of [petitioner] receiving this medicine and developing [the side effect.]" J.A. 236. Dr. Wolfson declined to specify the particular medication that he would prescribe for petitioner because he hoped that petitioner would play a role in choosing the medication. J.A. 238. Dr. Wolfson did indicate that three atypical drugs (quetiapine, olanzapine, and ziprasidone), which have a more "benign side effect" profile, made the "most sense." J.A. 238-239.

Dr. Wolfson stated that he had successfully used antipsychotic medication four out of five times to restore the competency of patients with delusional disorder. J.A. 240, 241, 261-263. Dr. Wolfson opined that he had "a good chance" of restoring petitioner's competency. J.A. 242.

At the hearing, petitioner again proffered the affidavit of Dr. Cloninger. J.A. 212, 300-301. Dr. Wolfson disagreed with Dr. Cloninger's conclusion that antipsychotic medication would provide no benefit to patients with delusional disorder. J.A. 244-248, 274-276. Dr. Wolfson also believed that Dr. Cloninger's proposed course of treatment involving access to exercise, reading material, and anti-depressants was "insufficient" to treat petitioner. J.A. 248. He explained that "[i]f we were having this conversation in 1935, that would be the best I would be able to offer him. But, this is unsupported, perhaps even irresponsible * * * as an adequate way to address [petitioner's] difficulties." *Ibid.*[4]

[4] Petitioner also proffered a report on an unidentified patient diagnosed with delusional disorder by Dr. Daniel Greenstein, a forensic psychologist at the Bureau of Prisons' Metropolitan Correctional Center in Chicago, Illinois. J.A. 212-214, 300-302. In his report, Dr. Greenstein stated that "[d]elusional disorder does not typically respond to pharmacological intervention or psychotherapy." J.A. 214. Dr. Wolfson believed that Dr. Greenstein's statement was "incorrect." *Ibid.*

3. On August 9, 2000, the magistrate judge ordered that petitioner be involuntarily administered antipsychotic medication. J.A. 320-338. He found that petitioner posed "a danger to himself and others at the institution," J.A. 333, that antipsychotic medications were "the only way to render [petitioner] not dangerous and competent to stand trial," J.A. 335, and that there were "no other less restrictive means by which this may be accomplished." *Ibid.*

The district court affirmed the magistrate judge's order. J.A. 339-355. The court concluded that the magistrate judge had clearly erred in finding that "[petitioner] present[ed] a danger to himself or others." J.A. 349. The court found, however, that involuntary medication was justified by the need to restore petitioner to competency. The court concluded "(1) that anti-psychotic drugs are medically appropriate for [petitioner], (2) that they represent the only viable hope of rendering [petitioner] competent to stand trial, and (3) that the administration of such drugs appears necessary to serve the government's compelling interest in obtaining an adjudication of [petitioner's] guilt or innocence of numerous and serious charges." J.A. 354.

4. A divided panel of the court of appeals affirmed. J.A. 356-382. The court upheld the district court's ruling that the evidence did not support a finding that petitioner posed a danger to himself and others at the medical center. J.A. 363. Relying on *Riggins* v. *Nevada*, 504 U.S. 127 (1992), and *Washington* v. *Harper*, 494 U.S. 210 (1990), the court of appeals held that, in order for the government to involuntarily medicate an individual:

> First, the government must present an essential state interest that outweighs the individual's interest in remaining free from medication. * * * Second, the government must prove that there is no less intrusive way of fulfilling its essential interest. * * * Third, the government must prove by clear and convincing evidence that the medication is medically appropriate.

J.A. 367-368 (citations omitted).

The court of appeals held that the government had met its burden under those standards. The court first concluded that "[t]he government has an essential interest in bringing a defendant to trial." J.A. 368. The court noted that "[n]ot all charges, however, are sufficient to justify forcible medication of a defendant; rather, the charges must be serious." *Ibid.* The court decided that the 62 charges of fraud and single count of money laundering were serious enough to outweigh petitioner's significant liberty interest in refusing antipsychotic medication. J.A. 369. The court declined to rely on the government's interest in adjudicating the attempted murder charges relating to the FBI agent and a witness because the court thought it "possible that [petitioner's] threats after his first indictment were a manifestation of his delusional disorder." J.A. 369 n.8.

Second, the court of appeals upheld the district court's finding that there were no less intrusive means by which the government could achieve its essential interest in bringing petitioner to trial. J.A. 369-370. The court observed that "[b]oth Dr. Wolfson and Dr. DeMier testified that antipsychotic medication [was] the most effective treatment for delusional disorder and that it [was] the only way [petitioner] could be restored to competency." J.A. 369. The court also noted that the affidavit from petitioner's psychiatrist, Dr. Cloninger, who disputed the efficacy of the medication, "did not suggest any alternative means of restoring competency." J.A. 370.

Third, the court of appeals found that the government had shown by clear and convincing evidence that there was "a sufficient likelihood that antipsychotic medication [would] restore [petitioner's] competence," J.A. 374; "that the side-

effects produced by the medication could be minimized through careful treatment and changing medications and dosages," *ibid.*; and that the "benefits outweighed the risks associated with antipsychotic drugs." J.A. 375.

The court of appeals next held that the district court had "properly considered [petitioner's] Sixth Amendment right to a fair trial." J.A. 375. The court explained that "before forcibly medicating an accused, there must be evidence that he will be able to participate in a fair trial." J.A. 376. Here, "the medical evidence presented indicated a reasonable probability that [petitioner] will fairly be able to participate in his trial." *Ibid.* Actual effects on competency and demeanor, the court added, may be evaluated after the medication. The court noted that the district court had indicated "its willingness to re-examine [petitioner's] Sixth Amendment claim after the medication regime has begun." *Ibid.*

Judge Bye dissented. J.A. 377-382. Judge Bye would have applied "strict scrutiny" to the review of whether petitioner could be involuntarily medicated to restore his competence. J.A. 377. The dissent also argued that the government had failed to satisfy the first part of the majority's three-part test because "the [fraud and money laundering] charges against [petitioner] are not sufficiently serious." *Ibid.*[5]

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[5] The court of appeals did not discuss whether it had jurisdiction over the district court's interlocutory order. The United States agrees with the courts of appeals that have addressed the issue and have concluded that an order approving the involuntary medication of a pre-trial detainee constitutes an appealable collateral order under *Cohen* v. *Beneficial Industrial Loan Corp.*, 337 U.S. 541, 546 (1949). *United States* v. *Gomes*, 289 F.3d 71, 79 (2d Cir. 2002), petition for cert. pending, No. 02-7118 (filed Oct. 22, 2002); *United States* v. *Morgan*, 193 F.3d 252, 258-259 (4th Cir. 1999); *United States* v. *Brandon*, 158 F.3d 947, 950-951 (6th Cir. 1998); cf. *United States* v. *Weissberger*, 951 F.2d 392, 396 (D.C. Cir. 1991) (court had jurisdiction under *Cohen* to review order permitting involuntary confinement for competency examination under 18 U.S.C. 4241(a)).

SUMMARY OF ARGUMENT

The government has a compelling interest in adjudicating serious criminal charges. At the same time, an incompetent defendant cannot be brought to trial unless his competence can be restored. To permit criminal charges to be resolved, the government therefore has an essential interest in making efforts to restore competence. When, as in this case, the government proposes to restore a defendant's competence through antipsychotic drugs, the defendant's significant liberty interest in avoiding unwanted treatment requires the government to bear the burden of justifying the proposed medical intervention. That burden can be met when there is a substantial probability that medication will restore competence, the medication is medically appropriate, there is no less intrusive alternative, and the defendant, if restored to competence, can be expected to receive a fair trial.

A. The government's interest in prosecuting charges of serious crime is compelling. Felony offenses traditionally have been recognized as serious offenses, whether or not a particular offense involves violence. Many serious offenses, such as treason, espionage, and drug trafficking, are serious even if not violent. Widespread fraudulent schemes also inflict great harm on society and constitute serious offenses.

When involuntary medication is necessary to restore competence, no alternative to that approach would adequately serve the government's interest. Absent restoration of competence, the defendant cannot be tried. It is therefore possible that a defendant may be set free entirely, despite a grand jury indictment charging serious crimes. And the function of a criminal trial publicly to find facts and impose consequences plainly cannot be duplicated by steps such as civil commitment. Civil commitment also imposes unique restraints on the defendant's own liberty interests. Absent treatment, the confinement may continue indefinitely. And during such confinement, the defendant can be ordered

medicated, if necessary for institutional reasons or his own safety, without the safeguards afforded in a criminal case of prior judicial review.

B. The question then becomes whether involuntary medication is likely to restore competence and is medically appropriate. The professional literature, the experience of the Bureau of Prisons, and the record in this case establish that for psychotic disorders, there is a high likelihood that antipsychotic medication will restore competence and that the medication is medically appropriate (and often indispensable) to treat the devastating symptoms of schizophrenia and other diseases. No less restrictive form of intervention is likely to restore competence, and, by itself, no alternative intervention can serve the defendant's medical interests. It is well documented that antipsychotic medication can operate to clear the patient's mind of delusions and hallucinations and restore his capacity for rational thinking, coherent communication, and goal-directed behavior—attributes that are central to competence in a criminal case.

Antipsychotic medication does have side effects, and those effects must be considered in the determination of medical appropriateness—as well as in determining whether the defendant, if restored to competence, will receive a fair trial. But all medications have side effects, and medical appropriateness necessarily turns on a balancing of risks and benefits. In the case of many devastating psychotic diseases, the potential side effects, though serious, are more than amply offset by the likely benefits. Most risks, in addition, can be medically managed—by reducing dosages, changing medications, or prescribing counteracting agents. And the most severe potential side effects are unlikely to emerge in the short-term period during which involuntary medication is necessary for a defendant to prepare for and stand trial.

Equally important, psychiatric medication has progressed dramatically since *Riggins*. A new generation of "atypical"

antipsychotic medications has greatly reduced the most serious side effects. Particularly in light of those advances, medical professionals can reliably attest to the appropriateness and likely success of medication in restoring competence, and courts can reliably make findings that justify ordering such treatment, consistent with the defendant's substantive due process rights.

C. The First Amendment does not preclude the use of involuntary medication to restore competence. The expressive and freedom-of-thought interests that the First Amendment protects are also encompassed by the liberty interests at stake in substantive due process analysis. And antipsychotic medication is likely to enhance, rather than suppress, a psychotic or delusional patient's ability to think and communicate, faculties that have often been shattered by the disease itself.

D. The Fifth and Sixth Amendment rights to a fair trial can be fully protected when a court orders involuntary medication. The opinion of the Court in *Riggins* and Justice Kennedy's concurrence observed that antipsychotic medication can have side effects that can produce trial prejudice. But the experience of many defendants who have been restored to competence after receiving antipsychotic medication reveals that such prejudice is not a necessary consequence of medication. The goal of the medication is to restore competence, and if the defendant cannot stay awake, follow the proceedings, or communicate with counsel, the standard of competence has not been achieved. When competence is achieved, it is reasonable to expect that side effects—such as impairments of a defendant's demeanor or sedation—can be medically managed and controlled. The concrete evaluation of what side effects materialize, and whether they can be controlled to avoid an unfair trial, thus should be made after medication has restored competence. In addition, careful management of the trial itself, as well as

testimony and jury instructions explaining any effects of the medication, can further reduce any risk of prejudice.

Finally, a defendant has no constitutional right to appear before the jury in an unmedicated, psychotic state in order to bolster a mental-status defense. A trial of a defendant in such state is unlikely to occur, since the defendant probably would not be competent. And a mentally ill defendant has no right to appear before the jury in the purported mental state that he possessed on the occasion of the crime. Proof of his mental state can be made by the normal means: medical reports, eyewitness testimony, expert testimony, and the defendant's own recollections. Those means are adequate to enable the defendant to make his defense.

E. Applying those standards, the courts below correctly found that an order of antipsychotic medication of petitioner is justified. The felony fraud charges against him are serious; antipsychotic medication, and no less intrusive alternative, is likely to restore petitioner's competence; such medication is medically appropriate; and there is every reason to believe that he will receive a fair trial if restored to competence.

ARGUMENT

THE DISTRICT COURT'S ORDER THAT PETITIONER BE INVOLUNTARILY MEDICATED TO RESTORE HIS COMPETENCE IS CONSTITUTIONAL

A defendant is incompetent to stand trial when he cannot understand the nature of the criminal proceedings and cannot cooperate with counsel in his defense. *E.g.*, *Cooper* v. *Oklahoma*, 517 U.S. 348, 354 (1996). When a defendant's incompetency precludes the adjudication of serious criminal charges, there is a compelling governmental interest in taking reasonable measures to restore a defendant's competency. Often, as in this case, attainment of that interest requires the administration of antipsychotic medication.

When the defendant resists, such a step implicates his significant liberty interest in avoiding unwanted medication, as well as his right to a fair trial. Those interests are properly reconciled by requiring the government to show, before involuntarily medicating a defendant, that: (1) the administration of antipsychotic drugs has a substantial probability of restoring the defendant's competency; (2) the medication is medically appropriate; (3) no less intrusive measures will serve the government's interest in restoring competence; and (4) it is reasonable to expect that the defendant, if restored to competence, will be able to receive a fair trial. On the facts of this case, all of those factors were established.

I. THE INVOLUNTARY ADMINISTRATION OF ANTIPSYCHOTIC MEDICATION TO RESTORE A DEFENDANT'S COMPETENCE TO STAND TRIAL ON SERIOUS CHARGES CAN BE ORDERED CONSISTENT WITH THE DEFENDANT'S SUBSTANTIVE DUE PROCESS RIGHTS

"So-called 'substantive due process' prevents the government from engaging in conduct that 'shocks the conscience,' or interferes with rights 'implicit in the concept of ordered liberty.'" *United States* v. *Salerno*, 481 U.S. 739, 746 (1987) (quoting *Rochin* v. *California*, 342 U.S. 165, 172 (1952) and *Palko* v. *Connecticut*, 302 U.S. 319, 325-326 (1937)). "[I]dentifying the contours" of substantive due process "involves a definition of the protected constitutional interest, as well as identification of the conditions under which competing state interests might outweigh it." *Harper*, 494 U.S. at 220 (quoting *Mills* v. *Rogers*, 457 U.S. 291, 299 (1982)). This Court has made clear that an individual has a significant liberty interest in avoiding the involuntary administration of antipsychotic medication. *Riggins*, 504 U.S. at 134; cf. *Cruzan* v. *Director, Mo. Dep't of Health*, 497 U.S. 261 (1990). Such an interest, however, is "not absolute," because not

every infringement of a liberty interest violates the Constitution. *Youngberg* v. *Romeo*, 457 U.S. 307, 320 (1992). An "individual's strong interest in liberty," even though "importan[t] and fundamental," may, "in circumstances where the government's interest is sufficiently weighty, be subordinated to the greater needs of society." *Salerno*, 481 U.S. at 750-751.

A. Substantive Due Process Analysis Requires Balancing The Government's Interests Against The Liberty Interest Of The Defendant

In *Harper*, 494 U.S. at 227, this Court held that substantive due process does not bar the government from involuntarily medicating a convicted prisoner who is dangerous to himself or others, when the medication is medically appropriate. In so holding, the Court weighed the government's interest in prison "safety and security" against the defendant's substantive liberty interest, and concluded that the proper standard of review asked whether the proposed intrusion was "reasonably related to legitimate penological interests." *Id.* at 223 (quoting *Turner* v. *Safely*, 482 U.S. 78, 89 (1987)).

In *Riggins*, 504 U.S. at 135, the Court considered a claim that the involuntary medication of a defendant with an antipsychotic drug (Mellaril) violated the defendant's Sixth and Fourteenth Amendment rights because it created a risk of trial prejudice and because the State had failed "to establish the need" for the medication. The Court held that "since the District Court allowed administration of Mellaril to continue without making *any* determination of the need for this course or *any* findings about reasonable alternatives," *id.* at 135-136, the creation of possible trial prejudice to the defendant was unjustified. *Id.* at 137-138. The Court observed that, although "trial prejudice can sometimes be justified by an essential state interest," the record in the

case contained "no finding that might support a conclusion that administration of antipsychotic medication was necessary to accomplish an essential state policy." *Id.* at 138. The Court stated, however, that "the State might have been able to justify medically appropriate, involuntary treatment with the drug by establishing that it could not obtain an adjudication of [the defendant's] guilt or innocence by using less intrusive means." *Id.* at 135.

The Court in *Riggins* stated that it had not adopted "a standard of strict scrutiny," explaining that it had no "occasion to develop substantive standards for judging forced administration of such drugs in the trial or pretrial settings." 504 U.S. at 136. As in other cases involving substantive due process, however, the determination of whether, and under what circumstances, the government may justify involuntary treatment with antipsychotic medication in order to restore a defendant's competence requires careful examination of the competing interests. In a variety of analogous contexts this Court's substantive due process jurisprudence has applied such a balancing test, weighing the competing interests in order to determine when an intrusion on a significant liberty interest is justified. In *Youngberg* v. *Romeo*, 457 U.S. at 320-322, for example, the Court determined that the liberty interest of involuntarily-committed mentally disabled persons to enjoy freedom of movement within the institution may be restricted based on an exercise of the institution's professional judgment. See also *Bell* v. *Wolfish*, 441 U.S. 520, 537-538 (1979) (upholding the constitutionality of restrictions on pre-trial detainees' liberty). The Court has similarly balanced the competing interests in order to determine when the government may override a defendant's liberty interest and detain him pre-trial based on threats of future dangerousness, *Salerno*, 481 U.S. at 746-751; when a defendant found incompetent to stand trial may be thereafter confined; *Jackson* v. *Indiana*, 406 U.S. 715, 738 (1972);

and when a defendant found not guilty by reason of insanity may be subject to involuntary commitment, *Foucha* v. *Louisiana*, 504 U.S. 71, 79 (1992); *Jones* v. *United States*, 463 U.S. 354, 368 (1983).

The same approach is warranted here. In developing a substantive standard for when involuntary medication is permissible, the critical factors are the importance of the government's interest in adjudicating serious criminal charges, the lack of adequate alternatives to involuntary medication, the consequences for the defendant's liberty interests of administering or (not administering) medication, and the ability of a medicated defendant to receive a fair trial. Consideration of those factors leads to the conclusion that the government's interest in adjudicating serious offenses is sufficiently important to outweigh an individual's liberty interest in refusing unwanted antipsychotic medication, when the government can demonstrate that the medication has a substantial probability of restoring competence and is medically appropriate; that there is no reasonable and less intrusive alternative; and that it is reasonable to expect that the defendant, if restored to competency, will receive a fair trial.[6]

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[6] The majority of the courts of appeals have concluded that the appropriate form of review involves "heightened" but not "strict scrutiny." J.A. 366-367 n.7; *Gomes*, 289 F.3d at 82; *United States* v. *Weston*, 255 F.3d 873, 880 (D.C. Cir.), cert. denied, 122 S. Ct. 670 (2001); but see *United States* v. *Brandon*, 158 F.3d at 956-961. That conclusion is correct. Petitioner urges the Court to apply "strict" scrutiny (Br. 35-36), but this Court's substantive due process decisions do not require that conclusion. A defendant's wish to remain incompetent in a criminal case by refusing medically appropriate and necessary medication should not be regarded as a fundamental right that triggers strict scrutiny. Cf. *Washington* v. *Glucksberg*, 521 U.S. 702, 720-721 (1997) (requiring a "careful description" of the asserted interest to determine whether it is, "objectively, 'deeply rooted in this Nation's history and tradition.'") (citations omitted). In the present context (and regardless of the name attached to the form of judicial review), the test should not be set so unrealistically high that medically

B. The Government Has An Overriding Interest In Adjudicating Serious Criminal Charges

The government has a compelling interest in bringing a defendant to trial after probable cause has been found to justify prosecution for a serious criminal offense. As this Court noted in *Riggins*, the "[c]onstitutional power to bring an accused to trial is fundamental to a scheme of 'ordered liberty' and prerequisite to social justice and peace." 504 U.S. at 135-136 (quoting *Illinois* v. *Allen*, 397 U.S. 337, 347 (1970) (Brennan, J., concurring)); see also *Winston* v. *Lee*, 470 U.S. 753, 762 (1985) (noting that "the community's interest in fairly and accurately determining guilt or innocence" is "of great importance"). The Court has repeatedly referred to the government's "compelling interest in finding, convicting, and punishing those who violate the law." *Moran* v. *Burbine*, 475 U.S. 412, 426 (1986); accord *Texas* v. *Cobb*, 532 U.S. 162, 172 (2001); *McNeil* v. *Wisconsin*, 501 U.S. 171, 181 (1991); *Richardson* v. *Marsh*, 481 U.S. 200, 210 (1987); *Garrett* v. *United States*, 471 U.S. 773, 796 (1985) (O'Connor, J., concurring). "The sole constitutional mechanism for the government to accomplish its essential policy is to take [a defendant] to trial." *United States* v. *Weston*, 255 F.3d 873, 882 (D.C. Cir.) (citing U.S. Const. Amend. V)), cert. denied, 122 S. Ct. 670 (2001). Accordingly, the government's interest extends to "ensuring that persons accused of crimes are

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responsible steps to restore competence are automatically foreclosed. Nor should the government's interest in adjudicating guilt on serious criminal charges be wholly subordinated to an individual's liberty interests. To the contrary, this Court's decisions have recognized that even significant liberty interests may be subject to overriding societal interests. *E.g.*, *Salerno*, 481 U.S. at 750-751 (pre-trial detention for a "serious" crime based on proof of dangerousness); *Addington* v. *Texas*, 441 U.S. 418, 430-431 (1979) (civil commitment based on "clear and convincing" evidence; rejecting a beyond-a-reasonable-doubt standard that would foreclose civil commitment "for many patients desperately in need of institutionalized psychiatric care").

available for trials and, ultimately, for service of their sentences." *Bell* v. *Wolfish*, 441 U.S. at 534.

Petitioner errs in asserting (Br. 35, 36, 42) that this Court's decisions bar the government from seeking an order of involuntary medication for "prosecutorial" purposes. Certain extreme intrusions on a suspect's bodily integrity are unjustified in order to investigate crime or gather evidence. *Rochin*, 342 U.S. at 172 (stomach pumping is "too close to the rack and the screw to permit of constitutional differentiation"). Here, however, the interest at stake is society's essential concern that serious criminal charges, brought by a grand jury, receive a fair determination in open court. Even with respect to evidence gathering, there is no absolute rule against medical intrusions. *Schmerber* v. *California*, 384 U.S. 757 (1966) (taking of blood sample permitted). There is even less warrant for an absolute rule that would prevent medically appropriate efforts to obtain a fair adjudication of criminal charges through antipsychotic medication that restores a defendant's competence.

The government's interest is not diminished by the fact that a pre-trial detainee is "presumed to be innocent" until convicted of a crime. Pet. Br. 23, 24, 25, 36. This Court has explained that "[t]he presumption of innocence is a doctrine that allocates the burden of proof in criminal trials; it also may serve as an admonishment to the jury to judge an accused's guilt or innocence solely on the evidence adduced at trial." *Bell*, 441 U.S. at 533. The presumption of innocence, however, "has no application to a determination of the [substantive due process] rights of a pretrial detainee during confinement before his trial has even begun." *Ibid.*

1. The government's interest in adjudicating guilt on a serious offense is not limited to violent offenses

Petitioner and some of his amici argue that the government's interest is not sufficiently weighty when the

defendant wishes to remain incompetent to stand trial on charges that do not involve "violence." Pet. Br. 35-38, 41-43; Rutherford Am. Br. 17-18; ACLU Am. Br. 1-19. There is no sound basis for that limitation. The government has an unquestioned vital interest in prosecuting and punishing violent crime. But other breaches of the public order likewise demand judicial resolution. Petitioner is charged with the commission of felony offenses, and, as such, those charges are sufficiently serious to justify the administration of medication to restore competence.[7]

First, the government has a compelling interest in adjudicating an individual's guilt or innocence of felony charges. Felonies represent a traditional category of serious offenses, whether or not the offense involves violence. See *Nichols* v. *United States*, 511 U.S. 738, 743 n.9 (1994) (right to counsel under *Gideon* v. *Wainwright*, 372 U.S. 335 (1963), applies to all felony offenses). Indeed, there are many serious offenses, such as treason, espionage, acts of economic terrorism, and drug trafficking, that may be committed without resort to violence. Cf. *Salerno*, 481 U.S. at 750 (Bail Reform Act focused on a narrow category of "extremely serious offenses," including drug trafficking). Violence may also be absent in offenses that involve major economic losses, such as large-scale fraud cases for which the government seeks

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[7] The court of appeals held that it would not consider that petitioner is charged with violent offenses (conspiracy to murder an FBI agent and a witness) because, in the court's view, "[i]t is possible that [petitioner's] threats after his first indictment were a manifestation of his delusional disorder." J.A. 369 n.8. This Court's formulation of the question presented presupposes that the defendant was charged with non-violent offenses. J.A. 334. But the possibility that a defendant's violent crimes were a "manifestation" of his mental illness should not preclude the government from involuntarily medicating him in order to go to trial on those charges. The government's interest in obtaining an adjudication on serious criminal charges is not diminished because of the possibility that the defendant's mental disease *may* afford a defense; it is the purpose of the trial to see if it does.

restitution for numerous victims. The government's interest in prosecuting those offenses is not invariably less compelling than its interest in prosecuting violent offenses.

Second, limiting the government's interest to offenses that are inherently violent overlooks that many defendants who commit nonviolent crimes may also commit violent criminal acts to avoid apprehension or conviction. "The fact that a person has been found * * * to have committed a criminal act certainly indicates dangerousness." *Jones*, 463 U.S. at 364. There is a significant risk, for example, that persons charged with crimes of pure theft will resort to violence in response to, or to thwart, law enforcement. "[C]rimes of theft frequently may result in violence from the efforts of the criminal to escape or the victim to protect property or the police to apprehend the fleeing criminal." *Id.* at 365 n.14. This case similarly illustrates the point. After petitioner was indicted on the fraud and money laundering charges, he allegedly arranged to have murdered both the FBI agent who arrested him and a former employee at his dental office. The employee was allegedly targeted in retaliation for her cooperation with law enforcement and to prevent her from testifying against petitioner on the fraud charges. J.A. 23-29, 358.

Third, limiting the government's essential interest in adjudicating criminal charges to offenses involving violence would create difficult line-drawing problems. Under some definitions, offenses involving physical force against property constitute crimes of violence, while under other definitions, violent crimes are limited to offenses against persons. Compare 18 U.S.C. 16 ("crime of violence" includes offenses involving risk of "physical force against the person *or property* of another") (emphasis added), with 18 U.S.C. 924(e)(2)(B) ("violent felony" includes offenses that present risk "of physical injury to another"); cf. 18 U.S.C. 4246 (allowing involuntary commitment if person presents a "substantial risk of * * * *serious damage to property of another*) (emphasis added). Courts would also have to decide whether certain state law offenses, such as burglary, are violent offenses because of the potential risk of violence to persons, and whether such a determination is made according to the statutory elements or the facts underlying the charge. Cf. *Taylor* v. *United States*, 495 U.S. 575 (1990). Similar questions would arise for federal offenses such as the offense of unlawful possession of a firearm by a felon, in violation of 18 U.S.C. 922(g)(1). *E.g*, *United States* v. *Gomes*, 289 F.3d 71, 86 (2d Cir. 2002) (finding government had essential interest in adjudicating felon-in-possession offense), petition for cert. pending No. 02-7118 (filed Oct. 22, 2002); cf. *Stinson* v. *United States*, 508 U.S. 36, 39 & n.1 (1993) (discussing amendment to Sentencing Guidelines excluding felon-in-possession offenses from a career-offender predicate "crime of violence").

Fourth, the charged fraud offenses in this case illustrate why the government's interest in adjudicating non-violent felony offenses is weighty. The Court has in other contexts recognized that the government's interest in preventing fraud is "important" (*Watchtower Bible & Tract Soc'y of New York, Inc.* v. *Village of Stratton*, 122 S. Ct. 2080, 2089 (2002)), and "substantial" (*Village of Schaumburg* v. *Citizens for a Better Env't*, 444 U.S. 620, 636 (1980)). Accord *Riley* v. *National Fed'n of the Blind*, 487 U.S. 781, 792 (1988) (interest in protecting the public against fraud "is, of course, a sufficiently substantial interest to justify a narrowly tailored regulation").

Here, petitioner was charged with 56 counts of health care fraud, six counts of Medicaid fraud, and one count of money laundering based on a pervasive scheme to submit hundreds of false claims to Medicaid and private insurance companies between 1989 and 1997. The indictment alleges that petitioner, and employees at his direction, submitted manufac-

tured x-ray images and other altered dental records to Medicaid and private insurance companies to reflect dental problems that did not exist and dental services that were not performed. Those crimes harmed society by draining an important federal assistance program of its limited resources. The court of appeals correctly concluded that those charges were sufficiently serious to outweigh petitioner's liberty interest in avoiding forced medication. J.A. 368-369.

2. The alternatives to bringing petitioner to trial are inadequate to serve the government's interest

The Due Process Clause prohibits the criminal prosecution of a defendant who is not competent to stand trial. *Cooper*, 517 U.S. at 354; *Godinez* v. *Moran*, 509 U.S. 389, 396 (1993); *Medina* v. *California*, 505 U.S. 437, 439 (1992); *Drope* v. *Missouri*, 420 U.S. 162, 171 (1975); *Pate* v. *Robinson*, 383 U.S. 375 (1966). Thus, the recognition of a constitutional right to refuse medication necessary to restore competency to stand trial results, most immediately, in the inability of society to obtain a prompt resolution of pending criminal charges. In lieu of trial, the individual will either be released or involuntarily committed pursuant to 18 U.S.C. 4246. Neither alternative adequately vindicates the government's interest.

The government's "compelling interest in finding, convicting, and punishing those who violate the law" (*Moran* v. *Burbine*, 475 U.S. at 426) would be seriously undermined if an incompetent defendant cannot be brought to trial because of his decision to refuse medication necessary to restore competence. The possibility that the defendant will spontaneously regain competence without needed medication is remote at best. And even if the defendant at some later time receives treatment for his condition and his competency is restored, that event may occur too late for a successful prosecution. A defendant whose competence cannot be

restored may thereby achieve immunity from liability for his criminal acts.

Nor does the possibility of civil commitment adequately serve the governmental interests at stake. Under 18 U.S.C. 4241(d), a pre-trial detainee whose "mental condition has not so improved as to permit the trial to proceed * * * is subject to the provisions of section 4246." Under Section 4246(d), if the court following a hearing finds by clear and convincing evidence that "the person is presently suffering from a mental disease or defect as a result of which his release would create a substantial risk of bodily injury to another person or serious damage to property of another," the person must remain in the custody of the Attorney General for "treatment" unless a State will assume responsibility for him and his mental condition. *Ibid.*

As with a defendant who is released, the passage of time and the fading memories of witnesses may ultimately preclude the government from prosecuting the charges against a civilly committed defendant, even if he were to regain competence while involuntarily hospitalized. At a minimum, indefinite delay harms "[s]ociety's particular interest in bringing swift prosecutions," *Barker* v. *Wingo*, 407 U.S. 514, 527 (1972), not only because "[a]s the time between the commission of the crime and trial lengthens, witnesses may become unavailable or their memories may fade," *id.* at 521, but the delay prevents an adjudication that brings closure for the victims of the offense. And "even though civil commitment might reduce the danger to the community posed by an individual, it cannot address a host of other important societal concerns and values served by a criminal trial: 'the retributive, deterrent, communicative and investigative functions of the criminal justice system * * * serve to ensure that offenders receive their just deserts, to make clear that offenses entail consequences, and to discover what

happened through the public mechanism of trial.'" *Gomes*, 289 F.3d at 81 (quoting *Weston*, 255 F.3d at 882).

Involuntary commitment also does not well serve the liberty interest of the defendant who could face indefinite hospitalization in a federal prison hospital pursuant to 18 U.S.C. 4246. Absent medication, the person could simply be "warehoused" indefinitely, languishing without effective treatment for a serious mental disease, for periods well in excess of any sentence he may have served had he been found guilty of crimes for which he was charged. And a defendant who is hospitalized may in any event be medicated against his will under the standards of *Harper*. Bureau of Prisons' regulations authorize the forcible administration of medically appropriate antipsychotic medication if a psychiatrist, following an administrative hearing, determines that the inmate "is dangerous to self or others, is gravely disabled, or is unable to function in the open population of a mental health referral center or a regular prison." 28 C.F.R. 549.43(a)(5); cf. *Jurasek* v. *Utah State Hosp.*, 158 F.3d 506 (10th Cir. 1998) (applying *Harper* to permit forcible medication of patient involuntarily confined in state hospital upon showing that patient is dangerous to self or others or is gravely ill). In that situation, contrary to petitioner's assertion (Br. 38), an involuntarily committed patient will have *less* procedural protections than a pre-trial detainee, like petitioner, whom the government seeks to medicate to restore competency. Cf. *Harper*, 494 U.S. at 229-236 (judicial order not required to involuntarily medicate convicted prisoner).

C. Involuntary Medication Is Justified When There Is A Substantial Probability Of Restoring Competence And When Medically Appropriate

Because of the significant liberty interest of the defendant, the government must show that involuntary administration of antipsychotic medication is substantially likely to render the defendant competent to stand trial. Under this Court's decision in *Harper*, moreover, any involuntary administration of antipsychotic drugs must be medically appropriate. 494 U.S. at 227.

1. Antipsychotic medication, and no less-intrusive alternative, is substantially likely to restore competence

In *Jackson*, 406 U.S. at 738, this Court held that "a person charged by a State with a criminal offense who is committed solely on account of his incapacity to proceed to trial cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future." Cf. 18 U.S.C. 4241(d) (requiring Attorney General to "hospitalize [an incompetent] defendant for treatment * * * to determine whether there is a substantial probability that in the foreseeable future he will attain the capacity to permit the trial to proceed."). Just as the Constitution permits temporary and involuntary confinement based on a substantial probability of restoring competence, the Constitution likewise permits the temporary and involuntary administration of medically appropriate antipsychotic drugs when such treatment is substantially probable to restore competency.

As an empirical matter, medication with antipsychotic drugs is substantially likely to render a psychotic defendant competent to stand trial. The experience of the Bureau of Prisons is that antipsychotic medication is highly effective in restoring competency. Over a recent twelve-month period, the Bureau evaluated and treated 285 patients who were deemed under 18 U.S.C. 4241(d) to be incompetent to stand trial. Of the 226 persons who voluntarily accepted treatment, which in almost all instances included medication, 197 or 87.2% were restored to competency. Of the 59 persons

who were involuntarily medicated following an administrative hearing under the Bureau's regulations, 45 or 76.3% were restored to competency. That success rate is consistent with "[s]tudies [that] have concluded that the vast majority of incompetent defendants who are involuntarily committed for treatment are successfully restored to competence." American Psychological Ass'n Am. Br. 19.[8]

Petitioner suggests (Br. 38-40) that the government must show with "certainty" that medication will restore a defendant's competency to stand trial. Even when the government seeks to deprive a person of liberty by convicting him of a crime and punishing him, however, certainty is not required. See *Addington* v. *Texas*, 441 U.S. 418, 430 (1979) (beyond-a-reasonable-doubt standard does not require certainty beyond *any* doubt). And as the D.C. Circuit in *Weston* has explained, "[e]ven narrow tailoring in strict scrutiny analysis does not contemplate a perfect correspondence between the means chosen to accomplish a compelling governmental interest." 255 F.3d at 883. A requirement of certainty or near certainty overlooks the practical reality that neither physicians nor courts can make that sort of predictive medical judgment. *Addington*, 441 U.S. at 430 ("The subtleties and nuances of psychiatric diagnosis render certainties virtually beyond reach in most situations."); cf.

[8] A study of 61 defendants who were involuntarily treated to restore competency to face charges in New York found that 87% of the treated individuals were restored to competency and 93% were clinically improved. See B. Ladds et al., *Involuntary Medication of Patients Who Are Incompetent to Stand Trial: A Descriptive Study of the New York Experience with Judicial Review*, 21 Bull. of the Am. Acad. Psychiatry Law 529, 529-545 (1993); B. Ladds et al., *The Disposition of Criminal Charges After Involuntary Medication to Restore Competency to Stand Trial*, 38 J. Forensic Sci. 1442, 1442-1459 (1993). A similar study of 205 defendants found incompetent to face charges under California law reports a 90% success rate from anti-psychotic medication. L. Pendelton, *Treatment of Persons Found Incompetent to Stand Trial*, 137 Am. J. Psychiatry 1098, 1098-1100 (1980).

Daubert v. *Merrell Dow Pharms. Inc.*, 509 U.S. 579, 590 (1993) ("Of course, it would be unreasonable to conclude that the subject of scientific testimony must be 'known' to a certainty; arguably, there are no certainties in science."). "The small possibility that antipsychotic medication will not make [a defendant] competent for trial is certainly tolerable considering that antipsychotic medication is the sole means for the government to satisfy its essential policy." *Weston*, 255 F.3d at 883.

In addition to showing a substantial likelihood that medication will render a defendant competent to stand trial, the government must show that no reasonable less-intrusive alternative to medication will accomplish the government's objective. For the vast majority of individuals with psychotic illnesses, there are no less intrusive methods of restoring competency. *Riggins*, 504 U.S. at 141 (Kennedy, J., concurring) ("For many patients, no effective alternative exists for treatment of their illnesses."). Indeed, neither petitioner nor the amici suggest that there are viable, less intrusive means to treat most psychotic disorders that result in the individual being incompetent to stand trial. Cf. American Psychological Ass'n Am. Br. 3, 12 (noting that non-drug therapies "are often not adequate by themselves to treat acute psychotic disorders" and that courts should "not force the government to put the defendant through a pointless exercise" of administering alternative treatments to medication).

2. Antipsychotic medication is medically appropriate

It is settled that antipsychotic drugs are medically appropriate for the treatment of psychosis. *Harper*, 494 U.S. at 229 ("the therapeutic benefits of antipsychotic drugs are well documented"); American Psychiatric Press, *Textbook of Psychopharmacology* Ch. 17, at 315 (A.F. Schatzberg & C.B.

Nemeroff eds., 2d ed. 1998) (*Textbook of Psychopharmacology*) ("Antipsychotic medications are effective for nearly every medical and psychiatric condition that results in psychosis."); accord National Institute of Mental Health, *Mental Health: A Report of the Surgeon General* 279-280 (1999) (*Mental Health*); American Psychiatric Ass'n Am. Br. 13-14; American Psychological Ass'n Am. Br. 3, 11.

a. Petitioner's characterization (Br. 18, 23, 32, 33, 42-43) of antipsychotic drugs as "artificially" "mind-altering" and producing a "synthetic sanity" reflects a misunderstanding of the nature and effects of both psychosis and antipsychotic drugs. Psychotic diseases such as schizophrenia and delusional disorders are serious and often debilitating diseases. For instance, "[s]chizophrenia is characterized by profound disruption in cognition and emotion, affecting the most fundamental human attributes: language, thought, perception, affect, and sense of self." *Mental Health* 269 (emphasis omitted). Similarly, delusions "seriously restrict" the "autonomy that comes from logical, realistic, self-serving thinking." A.R. Felthous, M.D. et al., *Are Persecutory Delusions Amenable to Treatment?*, 29 J. Am. Acad. Psychiatry Law 461, 462 (2001); see also A.A. Stone, M.D., *Commentary on Formulating Mental Health Codes for the World*, Psychiatric Times, July 2002, at 4 ("[D]elusions and hallucinations are not a manifestation of human autonomy; they are symptoms of a serious malfunction of the human brain.").

Antipsychotic drugs treat psychotic symptoms that interfere with a person's ability to think and communicate. Antipsychotic drugs "*restore normal* thought processes by clearing hallucinations and delusions." *Riggins*, 504 U.S. at 141 (Kennedy, J., concurring) (emphasis added). "The mental health produced by antipsychotic medication is no different from, no more inauthentic or alien to the patient than, the physical health produced by other medications,

such as penicillin for pneumonia." *Ibid.* (quoting American Psychiatric Ass'n Am. Br. 9). Thus, "[r]ather than mind restricting, the medication is mind liberating. It brings the possibility of a less tortured existence and improved functioning, and it can serve as the key to real, physical liberty * * * in the long run." A.R. Felthous, *supra*, 466; accord T.G. Gutheil, M.D. & P.S. Appelbaum, M.D. *"Mind Control," "Synthetic Sanity," "Artificial Competence," and Genuine Confusion: Legally Relevant Effects of Antipsychotic Medication*, 12 Hofstra L. Rev. 77, 118-119 (1983) ("[E]mpirical studies of antipsychotic drug effects on complex cognitive functions * * * overwhelmingly show a positive effect of the medications * * * [not] consistent with a view of these drugs as mind-altering, thought-inhibiting, or destructive of personality in a negative sense. In fact, * * * the medications reinforce the most important aspects of mental functioning.").

Conversely, refraining from treatment has the potential to engender permanent harm, by slowing the response to medication once it is initiated or diminishing the extent of response to the medication. *Mental Health* 274; J.A. 165, 216. "Without medicine," the patient also could remain "deluded and dangerous," and therefore subject to involuntary commitment of a lifelong duration. A.R. Felthous, *supra*, 461; pp. 25-26, *supra*.

Those considerations are particularly acute when the psychotic individual faces criminal charges. The loss of cognitive abilities and rational thinking deprives the individual of any chance of exercising control and autonomy in determining whether to accept responsibility for any criminal conduct, to fight the charges and assist counsel in his defense, or to play a meaningful role in a course of treatment while serving a sentence.

b. Any consideration of medical appropriateness must consider the potential side effects of antipsychotic drugs in

a given case. There are two types of such drugs, the older-generation of conventional or typical drugs, which include chlorpropromazine (Thorazine), thioridazine (Mellaril), haloperidol (Haldol), thiothixene (Navane), and pimozide (Orap), and newer "atypical" drugs, which include clozapine (Clorazil), risperidone (Risperdal), olanzapine (Zyprexa), quetiapine (Seroquel), ziprasidone (Geodon), and aripiprazole (Abilify). 2 *Kaplan & Sadock's Comprehensive Textbook of Psychiatry*, 2356-2377, 2455-2472 (B.J. Sadock & V.A. Sadock eds., 7th ed. 2000) (*Kaplan & Sadock*); *Textbook of Psychopharmacology* 309-321, 323-348. Conventional anti-psychotic drugs can be associated with extrapyramidal (muscular movement) side effects that include parkinsonism (tremor of the limbs, diminished range of facial expression, slowed functions), acute dystonia (severe involuntary spasms of the upper body, tongue, throat or eyes); akathesia (motor restlessness, often characterized by an inability to sit still); neuroleptic malignant syndrome (a very rare condition which can lead to death from cardiac dysfunction); and tardive dyskinesia (a neurological disorder characterized by involuntary, uncontrollable movements of various muscles, especially around the face). *Riggins*, 504 U.S. at 142-144 (Kennedy, J., concurring); *Harper*, 494 U.S. at 229-230; *Mills*, 457 U.S. at 293 n.1. Given the possible side effects from all medications, including anti-psychotic medications, the Bureau of Prisons requires its psychiatrists "to maintain patients on the lowest effective dose of medication." Federal Bureau of Prisons, U.S. Dep't of Justice, *Health Services Manual* Ch. IX, at 6 (Sept. 1996) (*BOP Health Services Manual*). The Bureau also requires that "[a]ll patients on psychiatric medications shall be monitored regularly for side effects; this must be documented in the health record. Particularly for patients maintained on psychiatric medications known to cause tardive dyskinesia, regular monitoring

shall be documented for the development of symptoms of this disease." *Ibid.*

The professional judgment of medical experts is that most side effects of conventional drugs can be monitored and controlled by altering the doses of a drug or changing or adding drugs, and most side effects cease when the drugs are discontinued. *Mental Health* 281; T.G. Gutheil, *supra*, 109; *Textbook of Psychopharmacology* 317; American Psychiatric Ass'n Am. Br. 11, 14-16. As the Second Circuit noted in *Gomes*, "the most harmful side effects associated with conventional antipsychotic medications are rare, result from years of usage, and, to the extent that they arise shortly after administration of the medication, are manageable." 289 F.3d at 84; *Weston*, 255 F.3d at 877. For instance, tardive dyskinesia "virtually never develops after only a few weeks or months of taking the antipsychotic drugs." J. Gorman, *The Essential Guide to Psychiatric Drugs* 219 (3d ed. 1997); see also T.G. Gutheil, *supra*, at 109 ("[T]ardive dyskinesia is generally mild, not necessarily progressive and very often disappears if antipsychotic medication can be halted."). There would therefore normally be virtually no heightened risk of tardive dyskinesia in the temporary administration of drugs in order to restore competence. The risk of side effects associated with the involuntary administration of medication is confined to the limited period necessary to restore the defendant's competence through the course of the legal proceedings. *Gomes*, 289 F.3d at 84.

Significantly, since *Riggins* was decided, medical science has dramatically advanced to produce 'atypical" drugs that treat psychoses with lower risks of the conventional drugs' side effects. *Gomes*, 289 F.3d at 83; *Weston*, 255 F.3d at 886 n.7. Although atypical drugs have their own side effects, such as "sedation, weight gain, sexual dysfunction, and other dose-related discomforts" (*Mental Health* 282), "the side-effect profiles are significantly improved from the older

generation, and the improvements include what strongly appears, from an accumulating body of evidence, to be a substantial reduction of the risk of tardive dyskinesia." American Psychiatric Ass'n Am. Br. 18; S. Caroff et al., *Movement Disorders Associated with Atypical Antipsychotic Drugs*, 63 J. Clin. Psychiatry 12, 16-17 (2002) (concluding that "all of the atypical antipsychotic drugs show a significantly reduced potential in causing acute EPS [extrapyramidal side effects] and other movement disorders" and that "[t]here is fairly consistent and convincing evidence that the atypical antipsychotics have a significantly reduced liability for TD [tardive dyskinesia]"); accord *Mental Health* 280-281; American Psychological Ass'n Am. Br. 22-25. As with the conventional drugs, it is also possible to manage the side effects, including sedation, of the new generation of drugs to minimize and counteract those effects.[9]

There is also little doubt that medical science will continue to develop new drugs that will increase the range of options and decrease the negative side effects. For example, when this case was decided in the lower courts, the new generation, atypical drugs were available only for oral administration and, therefore, could not be used to involuntarily medicate an uncooperative patient. J.A. 235-238 (testimony of Dr. Wolfson). Faced with the choice of conventional or

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[9] Significantly, sedation-type effects may decline as the patient acclimates to the medication. *Mental Health* 281 ("Many other side effects such as attention and vigilance problems, sleepiness, blurry vision, dry mouth, and constipation are worse in the initial weeks of treatment and usually taper off as a person adjusts to the medication."); American Psychiatric Ass'n, *Practice Guidelines for the Treatment of Psychiatric Disorders* 320 (2000) ("Sedation is most pronounced in the initial phases of treatment. Most patients develop some tolerance to the sedating effects with continued administration."). Sedation can also be reduced by medical management. *Ibid.* ("Lowering of the daily dose, consolidation of divided doses into one evening dose, or changing to a less sedating antipsychotic medication can be helpful.").

atypical medications, a defendant who is ordered to take antipsychotic medication may well decide to cooperate in taking one of the atypical drugs in an oral form. *Weston*, 255 F.3d at 886 n.7 (noting defendant's indication that "he would comply with court-ordered medication"); see also P.A. Nidich & J. Collins, *Involuntary Administration of Psychotropic Medication: A Federal Court Update*, 11 Health Lawyer 12, 14 n.21 (May 1999) (The "short-term usage of typical antipsychotics to stabilize a patient to allow him a choice of switching to one of the atypicals presents little risk of serious side effects and is consistent with the standard of care."). Moreover, the Food and Drug Administration (FDA) has now approved for intramuscular injection one atypical drug, ziprasidone (Geodon). See http://www.pfizer.com/hml/pi's/geodonpi.pdf. Other atypical drugs may be available in an injectable form in the future. S. Vedantam, *Implants May Reshape Schizophrenia Treatment*, Washington Post, Nov. 16, 2002 <http://www.schizophrenia-help.com> ("[T]he maker of risperidone, the country's most frequently prescribed atypical antipsychotic, is applying to the [FDA] to market an injectable version" that has been approved for use in the United Kingdom, Germany, Austria, New Zealand, Mexico, the Netherlands, and Switzerland.); *Company News: Eli Lilly & Co. Article*, N.Y. Times, Mar. 9, 2001 <http://premium.news.yahoo.com> (noting application for approval of an injectable form of Zyprexa).

c. "Whether a proposed course of action is 'medically appropriate' obviously depends on the judgment of medical professionals." *Weston*, 255 F.3d at 876. Thus, the question whether the risk of medication will outweigh the medical benefits to the patient will involve a case-specific inquiry in light of the patient's history, medical condition, and state of medical knowledge at the time of medication. Courts making such an inquiry should accord proper "deference * * * to medical professionals who have the full-time responsibility of

caring for mentally ill inmates * * * and who possess, as courts do not, the requisite knowledge and expertise to determine whether the drugs should be used in an individual case." *Harper*, 494 U.S. at 230-231 n.12; see also *Parham* v. *J.R.*, 442 U.S. 584, 607 (1979) ("neither judges nor administrative hearing officers are better qualified than psychiatrists to render psychiatric judgments") (citation omitted). In particular, "[t]he risks associated with antipsychotic drugs are for the most part medical ones, best assessed by medical professionals" who are presumed to act with the best interest of the patient in mind. *Harper*, 494 U.S. at 233.[10]

II. THE INVOLUNTARY ADMINISTRATION OF ANTIPSYCHOTIC MEDICATION THAT ACCORDS WITH SUBSTANTIVE DUE PROCESS DOES NOT VIOLATE THE FIRST AMENDMENT

Petitioner and his amici argue that the First Amendment prevents the forced administration of antipsychotic drugs because it alters the person's consciousness, and ability to think and communicate, from his pre-medicated psychotic state. Pet. Br. 24-25, 28-30; Rutherford Inst. Am. Br. 7-9; ACLU Am. Br. 6-9; CCLE Am. Br. 3-23; *United States* v. *Brandon*, 158 F.3d 947, 953 (6th Cir. 1998); *Bee* v. *Greaves*, 744 F.2d 1387, 1393-1394 (10th Cir. 1984), cert. denied, 469 U.S. 1214 (1985). The substantive due process inquiry already protects those interests, however, because they are part of the individual's liberty interest in refusing antipsychotic medication whose purpose "is to alter the chemical balance in a patient's brain, leading to changes, intended to be beneficial, in his or her *cognitive processes*." *Harper*, 494 U.S. at 229 (emphases added); see also American Psychological Ass'n Am. Br. 9. Because the First Amendment and due process interests are "in large part co-extensive," an order of involuntary medication that complies with substantive due process standards set forth above does not violate the individual's First Amendment rights. *Gomes*, 289 F.3d at 84.

In any event, even if an individual has a residual First Amendment interest that is distinct from his liberty interest, an order of involuntary medication is not a content-based regulation that would require strict scrutiny. See *Simon & Schuster, Inc.* v. *Members of the N.Y State Crime Victims Bd.*, 502 U.S. 105, 118 (1991). The purpose of an order of involuntary medication is to restore a defendant's competence to stand trial; such an order does not "proscrib[e] speech or even expressive conduct because of disapproval of the ideas expressed." *R.A.V.* v. *City of St. Paul*, 505 U.S. 377, 382 (1992) (citations omitted). Indeed, antipsychotic medications, "when properly used to treat the severely mentally ill, positively *promote* First Amendment interests by enhancing abilities to concentrate, read, learn, and communicate." American Psychiatric Ass'n Am. Br. 26; see also pp. 30-31, *supra*. Because an order of involuntary medication is, at most, a content-neutral regulation, it requires a level of intermediate scrutiny. *Ward* v. *Rock Against Racism*, 491 U.S. 781, 799 (1989) (restriction must "promote[] a substantial government interest that would be achieved less effectively absent the regulation") (quoting *United States* v. *Albertini*, 472 U.S. 675, 689 (1985)); accord *United States* v. *O'Brien*, 391 U.S. 367, 377 (1968). Substantive due process requires that the involuntary administra-

[10] There is no basis for petitioner's suggestion (Br. 49 n.10) that physicians employed by the Bureau of Prisons are unable to make independent medical judgments. In its treatment of mentally ill pre-trial detainees, the Bureau of Prisons serves the role of a "benign custodian of one legally committed to it for care and medical treatment." *United States* v. *Charters*, 863 F.2d 302, 312 (4th Cir. 1988) (en banc), cert. denied, 494 U.S. 1016 (1990); cf. *BOP Health Services Manual* Ch. IX, at 4 (in advising courts under 18 U.S.C. 4241(d), "[a]t all times, evaluators should take the position of working for the court, not for the Assistant United States Attorney or the defense attorney").

tion of antipsychotic medication be medically appropriate and that the medication, and not a reasonable less intrusive alternative, is substantially likely to restore competency. That heightened level of scrutiny is consistent with the First Amendment. *Gomes*, 289 F.3d at 84-85.

III. THE INVOLUNTARY ADMINISTRATION OF ANTIPSYCHOTIC MEDICATION IS CONSISTENT WITH A DEFENDANT'S FIFTH AND SIXTH AMENDMENT RIGHTS TO A FAIR TRIAL

A. Medication Is Not Likely To Prejudice Fair Trial Rights

1. In *Riggins*, this Court found that the involuntary administration of an older generation drug, Mellaril, in a dose "within the toxic range" could have violated the defendant's trial rights because the possible side effects of confusion or drowsiness could have affected, "not just [the defendant's] outward appearance, but also the content of his testimony on direct or cross examination, his ability to follow the proceedings, or the substance of his communication with counsel." 504 U.S. at 137; see also *id.* at 142-145 (Kennedy, J., concurring). Thus, in addition to the substantive due process standards set forth above, a court may not order involuntary medication with antipsychotic drugs if the medication is likely to impair the defendant's ability to receive a fair trial.

Where the court has determined that medication is consistent with substantive due process, a court ordinarily will conclude that medication is not likely to prejudice the defendant's fair trial rights. As discussed above, pp. 31-35, due process requires the court to consider the risk of side effects on the defendant in determining whether the medication is medically appropriate. Due process also requires that the medication must be substantially likely to render the defendant able to understand the nature and consequences of the proceedings and assist in his defense. Indeed, the purpose of administering antipsychotic medication is to allow the defendant to think and communicate rationally so he can fairly participate in the legal proceedings and assist his counsel. Those benefits "presumably will also translate into an improved capacity to communicate from the witness stand." *Weston*, 255 F.3d at 884; cf. *Riggins*, 504 U.S. at 136 (noting absence of a finding that the medication was administered to ensure that the defendant was competent to stand trial).

2. There also is good reason to conclude that defendants who are competent by virtue of antipsychotic medication are likely to receive a fair trial. "The great majority of trial-incompetent defendants are restored to trial-competency through the *voluntary* use of these same medications." B. Ladds et al., *The Disposition of Criminal Charges After Involuntary Medication to Restore Competency to Stand Trial*, 38 J. Forensic Sci. 1442, 1453 (1993) (*The Disposition of Criminal Charges After Involuntary Medication*) (emphasis added). Similarly, as observed above (at 27), 226 out of the 285 defendants adjudicated to be incompetent under Section 4241(d) (*i.e.*, approximately 80%) within a recent twelve-month period voluntarily accepted treatment.

Although the Bureau does not track the disposition of charges once a defendant is restored to competency, the study by Ladds et al., which examined the disposition of charges of 43 involuntarily medicated defendants, found "no evidence * * * that forced medication per se during a pretrial hospitalization worsens the outcome of pending criminal charges." *The Disposition of Criminal Charges After Involuntary Medication* 1457. Specifically, the study reported that most defendants entered into pleas that resulted in "markedly reduced" charges; that "[s]everal individuals gained freedom from confinement immediately"; and that

medication did not preclude "the successful assertion of an insanity plea." *Id.* at 1452, 1453, 1454.

B. Post-Medication Procedures Ensure That Medication Does Not Unduly Prejudice Fair Trial Rights

1. Where there is no sound reason to conclude, pre-medication, that antipsychotic drugs will impair a particular defendant's fair trial rights, the question whether a drug's side effects, if any, will impair those rights is premature until the drugs are administered. For that reason, the question whether the medication will adversely affect the defendant's fair trial rights "is best determined when the actual effects of the medication are known, that is, after he is medicated." *Weston*, 255 F.3d at 886 n.8; accord *Gomes*, 289 F.3d at 84 ("whatever the risk of side effects may be, we believe that they are best dealt with in the context of the individual case [post-medication] rather than by blanket judicial pronouncements"); J.A. 376 ("[W]e believe that the effects of the medication on [petitioner's] competency and demeanor may properly be considered once the medication is administered.").

The concern expressed in Justice Kennedy's concurrence in *Riggins*, 504 U.S. at 142-145, that side effects will undermine a defendant's right to a fair trial relied, to a large extent, on the side effects of the older generation of drugs. The newer generation of antipsychotic drugs has generally less significant side effects. *Weston*, 255 F.3d at 886 n.7. Indeed, the class of atypical drugs is defined by the drugs' ability to treat psychoses while producing minimal extra-pyramidal side effects. H. Meltzer & S. McGurk, *The Effects of Clozapine, Risperidone, and Olanzapine on Cognitive Function in Schizophrenia* 25(2) Schizophrenia Bull. 233, 235 (1999) ("Atypical antipsychotics are operationally defined as drugs that produce minimal extra pyramidal symptoms (EPS) at doses that produce effective antipsychotic action.").

In addition, some of the concerns, such as that a sedation effect will hinder a defendant's ability to follow the proceedings and assist counsel, directly bear on the issue of competence itself. A defendant who is too drowsy to understand the proceedings or assist counsel will not be found competent to stand trial. A further concern is that medication may be prescribed "for the very purpose of imposing constraints on the defendant's own will." 504 U.S. at 145 (Kennedy, J., concurring). That purpose, however, would not be a legitimate basis for medication designed to restore competence. The goal of restoring competence is to enable the defendant rationally to exercise his will. The medication is vital to attainment of that goal.

If a defendant does suffer any post-treatment side effects that threaten his rights to a fair trial, the ability of "treating physicians and the district court to respond to them substantially reduces the risk they pose to trial fairness." *Weston*, 255 F.3d at 885; accord *Gomes*, 289 F.3d at 84. Side effects can be monitored and controlled by the treating psychiatrist through reducing the dosage, adding a counteracting medication, or choosing a different medication. For example, adverse effects on the defendant's appearance and demeanor can be treated by adjusting the dosage of the medication, administering one of the anti-parkinsonism medications, or changing to one of the atypical medications. American Psychiatric Ass'n, *Practice Guidelines for the Treatment of Psychiatric Disorders* 321 (2000); accord 2 *Kaplan & Sadock* 2265-2266. Moreover, the district court may give appropriate instructions to the jury, such as informing the jury that the defendant is being administered medication, and allowing experts to testify about any effect of the medication. *Weston*, 255 F.3d at 886. The trial day can be shortened if necessary to avoid undue fatigue. Those post-medication procedures are constitutionally sufficient to

protect a defendant's Fifth and Sixth Amendment rights to a fair trial.

2. Petitioner argues (Br. 44) that no post-medication review can ameliorate the fact that medication that *is* effective in restoring competency will deprive a defendant "of the best evidence of his mental state at the time of the alleged crime—his own demeanor in an unmedicated state." That argument apparently posits a trial of an unmedicated psychotic defendant who could testify in a delusional or hallucinogenic state of mind. It is far from clear, however, that such a trial is possible. This Court has never held that a defendant can waive his right to be competent to stand trial, even were the defendant medicated to the point of being made competent to make such a waiver. Cf. *Riggins*, 504 U.S. at 136 ("The question whether a competent criminal defendant may refuse antipsychotic medication if cessation of medication would render him incompetent at trial is not before us."). And, while it is theoretically possible that a defendant at some indeterminate time in the future could become competent and yet remain mentally impaired to a degree sufficient to influence the jury, for seriously ill individuals, that possibility seems highly remote without antipsychotic medication. A constitutional right to refuse competency-restoring medication in order to preserve a hypothetical right to be tried in a mentally-impaired condition thus largely seems to contemplate a trial that will never occur.

Apart from the lack of practicability of the asserted right, "a defendant does not have an absolute right to replicate on the witness stand his mental state at the time of the crime." *Weston*, 255 F.3d at 884. As the D.C. Circuit has explained:

> A defendant asserting a heat-of-passion defense to a charge of first degree murder does not have the right to whip up a frenzy in court to show his capacity for rage, nor does a defendant claiming intoxication have the right to testify under the influence. There is little meaningful distinction between these cases and medication-induced competence to stand trial.

Ibid. Indeed, the American Psychiatric Association advises (Am. Br. 29) that "[a]n individual's psychotic state may not be evident in his or her appearance or demeanor" and that, even were the defendant to remain unmedicated at trial, the passage of time and his surroundings and circumstances at trial may alter his demeanor "from what it was at the time of the charged offense." There is, in addition, no necessary correlation between a defendant's present mental condition and whether his condition at the time of the alleged criminal act met the jurisdiction's legal definition of insanity (or other legal defenses). And there are ample other ways for a defendant to prove his impaired mental state at the time of the offense—through the testimony of examining physicians and other witnesses, taped interviews, psychiatric reports, and instructions to the jury about the effects of medication. Finally, the defendant himself can testify to his previous hallucinations or delusions. *Weston*, 255 F.3d at 884-885.

IV. THE ORDER FOR INVOLUNTARY ADMINISTRATION OF ANTIPSYCHOTIC MEDICATION IN THIS CASE IS PROPER

The court of appeals held that the government had proved the effectiveness of medication to restore petitioner's competency, the medical appropriateness of antipsychotic drugs, and the lack of reasonable alternatives "by clear and convincing evidence." J.A. 375.[11] The court of appeals also found

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[11] The importance and nature of the interests at stake here are comparable to the interests bearing on the decision to civilly commit an individual, *Addington* v. *Texas*, 441 U.S. at 427, in which the Court adopted the clear and convincing standard of proof. See also, *e.g.*, *Santosky* v. *Kramer*, 455 U.S. 745, 756-757 (1982) (termination of parental rights); *Woodby* v.

that there was evidence that petitioner's fair trial rights could be safeguarded if he was restored to competence by medication. J.A. 375-376. Those determinations are correct.

A. Antipsychotic Medication Is Substantially Likely And Necessary To Restore Petitioner's Competence

1. The record in this case establishes that antipsychotic medication is substantially likely to render petitioner competent to stand trial. Dr. DeMier testified to his belief that petitioner could "be restored to competency, as a result of treatment with anti-psychotic medications." J.A. 176. He testified that he had been involved in the treatment of two patients with delusional disorder who had been administered antipsychotic medication and that one patient had regained competency and the other had shown significant improvement. J.A. 174-176, 184-185.

Dr. Wolfson testified that he had treated between 1000 and 2000 patients with antipsychotic medication and that most of them had positive results. J.A. 233. He stated that he had successfully used antipsychotic medication four out of five times to restore the competency of patients with delusional disorder. J.A. 240-241, 261-263. Dr. Wolfson noted that the conventional wisdom was that patients with delusional disorder respond less well to antipsychotic medication than patients with other psychoses, but he doubted that conclusion based on his own experience. J.A. 243-244, 277. He observed that favorable results documented in a small series of case reports in the medical literature mirrored his experience. J.A. 243-244. Dr. Wolfson opined that, based on his experience, antipsychotic medication stood "a good chance" of restoring petitioner's competency. J.A. 242.

The American Psychological Association states (Am. Br. 17) that "there is no consensus among researchers that

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INS, 385 U.S. 276, 285-286 (1966) (deportation). That standard is therefore the appropriate one in this setting.

delusional disorder, persecutory type will respond favorably to antipsychotic drugs." The American Psychiatric Association, however, has concluded (Am. Br. 19-20) that "the evidence respecting treatment of delusional disorder," while "less definitive than for schizophrenia and other more common psychotic illnesses," "supports the findings about medication here–its medical appropriateness, the prospects for restoring competence, and the lack of realistic alternatives." See A. Munro, *Delusional Disorder, Paranoia and Related Illnesses* 6 (Cambridge Univ. Press 1999) ("Many anecdotal treatment results, and a small number of double-blind drug trials, appear to show a *consensus* that delusional disorder, despite its traditional resistance to treatment, can now be regarded as an eminently treatable illness.") (emphasis added); see also 1 *Kaplan & Sadock* 1263 (review of delusional disorder case studies in literature "indicated that 80.8 percent of cases either recovered fully or partially" as a result of antipsychotic medication).

In any event, there is no sound basis for imposing a constitutional requirement that courts in every case review the medical literature to determine whether a medical "consensus" has been achieved with respect to a particular course of treatment. In analogous contexts, this Court has not required such a showing but rather has required that the physician exercise her "professional judgment" in treating an involuntarily confined patient. *Youngberg*, 457 U.S. at 322; *Harper*, 494 U.S. at 230, 233; cf. *Daubert*, 509 U.S. at 594 ("general acceptance" is not a necessary precondition for admissibility of expert testimony under Federal Rules of Evidence).

2. The record equally establishes that there is no less intrusive means of treating petitioner's psychosis to render him competent to stand trial. Dr. DeMier testified at the evidentiary hearing that "anti-psychotic medication [was] clearly indicated, as it [was] the only treatment that we

could reasonably expect to improve [petitioner's] condition." J.A. 176. He believed that there was no "other effective method of treating [petitioner's] symptoms at this time," J.A. 177, and that antipsychotic medication was "the only effective means to improve his mental state." J.A. 184. Dr. Wolfson testified that antipsychotic medication was necessary to alleviate petitioner's symptoms before he could be treated with other non-drug therapies. J.A. 232-233, 262-264.

Neither petitioner nor the amici make any claim in this Court that there is a less intrusive means of restoring his competence to stand trial. American Psychological Ass'n Am. Br. 13-14 & n.11 ("For individuals with some diagnoses, however,—including delusional disorder—particular features of the disorder may present considerable obstacles to the effectiveness of non-drug therapy."); accord American Psychiatric Ass'n Am. Br. 20-21. Similarly, petitioner's expert, Dr. Cloninger "was not able to recommend a less intrusive alternative to restore [petitioner] to competency." J.A. 372.

B. Antipsychotic Medication Is Medically Appropriate

The record in this case also establishes that the likelihood and gravity of side effects of the antipsychotic medication do not outweigh the medical benefits to petitioner. Dr. DeMier acknowledged that there were "potentially significant side effects" from the medication, J.A. 185-187, but he believed that the medication provided "potentially, very significant recovery from symptoms." J.A. 185. Dr. Wolfson also acknowledged that antipsychotic medication had the potential to cause "unpleasant" side effects, such as dystonic reaction and sedation, J.A. 233-234, 240, but he believed that those side effects could be mitigated by other medicines or treatments. J.A. 234-235. As the court of appeals concluded, "the government proved that the side-effects produced by the

medication could be minimized through careful treatment and changing medications and dosages." J.A. 374.

Dr. DeMier also testified that the delay in treatment could adversely affect petitioner both by lengthening the amount of time it would take for the treatment to work and by diminishing the optimal response to the treatment. J.A. 165, 216. He stated that petitioner's condition had deteriorated since June 1999 and would continue to deteriorate if he were not treated with antipsychotic medication. J.A. 165-167, 172. Dr. Wolfson likewise anticipated that petitioner's condition would continue to deteriorate absent antipsychotic medication. J.A. 228.

Petitioner argues (Br. 18, 31, 33, 49) that the courts below could not determine whether antipsychotic medication was medically appropriate or effective in restoring competency, since Dr. Wolfson testified at the hearing that he did not want to commit himself to a particular drug because he wanted to give petitioner some control over his course of treatment. J.A. 238-239. Dr. Wolfson did recommend, however, that the atypical drugs quetiapine (Seroquel), olanzapine (Zyprexa), and ziprasadone (Geodon) "are the ones that make the most sense" and are the "most likely to have a benign side effect * * * profile." J.A. 238, 239. The court of appeals thus properly rejected petitioner's contention that "he was not given the opportunity to make specific objections to specific drugs." J.A. 374.

Dr. Wolfson's approach was medically proper, since the decision as to a particular medication and its precise dose must be determined according to what is appropriate at the time the medication is administered, given the patient's condition, and state of medical knowledge. There also is no point to seeking a judicial order authorizing only one form of a drug, for instance, an injectable conventional drug, if the patient, upon being advised of an involuntary medication order, decides to take one of the newer atypical drugs avail-

able only in a pill. Similarly, dosages may need adjustment and further medication may need to be prescribed in response to any side effects. Finally, the patient himself may wish to play some role after being advised of the risk of side effects. J.A. 297 (testimony of Dr. Wolfson) ("I see no benefit to saying, 'I will pick this drug now,' dogmatically, if it turns out that [petitioner] prefers Quetiapine to Olazapine, then there [is] no reason why he shouldn't have some input."). Any requirement of prior judicial approval for those subsidiary medical decisions could seriously interfere with the best medical interests of the patient and likewise could disrupt the government's attempt to render the defendant competent to stand trial.[12]

C. The Courts Below Appropriately Considered The Effects Of Antipsychotic Medication On Petitioner's Fair Trial Rights

The courts below found the evidence sufficient to indicate that petitioner "would be able to participate meaningfully in his trial while he is under the influence of the medication." J.A. 376. Petitioner errs in presuming (Br. 45) that the involuntary administration of antipsychotic medication is impermissible because it would impair his trials rights in being able "to pay attention to witnesses, attorneys, or anyone else in the courtroom, to listen and respond to questions, and to offer comments about the proceedings." In those situations, no trial would proceed because petitioner

[12] The government's ability to retain custody over a person to render him competent is not uncabined. Section 4241 allows the Attorney General to retain custody of a defendant for treatment only for a "reasonable period of time" during which there is "substantial probability" the person "will attain the capacity to permit the trial to proceed." 18 U.S.C. 4241(d)(2)(A). Although petitioner objects (Br. 21, 23, 36 n.5, 40) to the length of his confinement under Section 4241(d)(2)(A) during which he has not received treatment, petitioner has resisted all attempts to restore his competency through medication, and petitioner does not contend that there are alternative effective forms of treatment.

would not be competent to stand trial. As the district court explained, "[a] showing that he is unable to assist properly in his defense would result in a continued finding that defendant is not * * * competent to stand trial." J.A. 351.

Petitioner also argues that antipsychotic medication could render his appearance "drugged and listless" (Br. 44), "nervous and anxious or rigid and remorseless" (Br. 45), or "stiff[]" (Br. 46). As the magistrate judge explained, however, "Dr. Wolfson intends to use atypical anti-psychotic drugs with a low side effect profile when medicating [petitioner.] Dr. Wolfson also intends to avoid sedating [petitioner], because his purpose is to allow him to participate meaningfully in his trial." J.A. 334-335; see also J.A. 234 ("Obviously, our goal is to get patients back so they can defend their cases, and having them sleeping in the courtroom is not the desirable goal, so I tend to choose medications that do that less.").

Furthermore, the district court can examine all of petitioner's fair trial claims after petitioner is treated. Until that time, petitioner's hypotheses about the effects from medication on his demeanor and cognitive abilities are premature. Indeed, the district court in this case "noted its willingness to re-examine [petitioner's] Sixth Amendment claim after the medication regimen has begun." J.A. 376; see also J.A. 352 ("In its capacity as the trial court in this case, the Court here states that if medication is administered and the defense presents argument and evidence concerning its adverse effect on [petitioner] to defend himself, the Court will give the issue careful consideration."). In short, "[t]he evidence offered, that the drugs should not interfere with [petitioner's] right to a fair trial, as well as post-medication procedures that ensure he will not be tried unfairly, are sufficient to protect" petitioner's right to a fair trial. J.A. 376.

Petitioner's intent to present a diminished capacity defense (Br. 13-14, 43-44) also does not justify the conclusion

that he cannot be involuntarily medicated in order to restore his competency. Petitioner does not argue that he can constitutionally be tried in his unmedicated delusional state, see p. 42, *supra*, and on this record, medication is the *sole* means reasonably likely to render petitioner able to stand trial on the fraud (and attempted murder charges) in the foreseeable future. Petitioner also does not dispute that there is other extensive evidence of his history of mental illness, and there is no basis for presuming at this time that the medication will prejudice petitioner in testifying about his prior delusional beliefs. In those circumstances, petitioner has no constitutional right to refuse the administration of medically appropriate antipsychotic medication necessary to obtain an adjudication of the pending charges.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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APPENDIX

1. The First Amendment to the United States Constitution provides in relevant part:

> Congress shall make no law * * * abridging the freedom of speech.

2. The Fifth Amendment to the United States Constitution provides in relevant part:

> No person shall * * * be deprived of life, liberty, or property, without due process of law.

3. The Sixth Amendment to the United States Constitution provides in relevant part:

> In all criminal prosecutions, the accused shall enjoy the right to a speedy and public trial, by an impartial jury * * *, and to have the Assistance of Counsel for his defence.

4. Section 4241, of Title 18, U.S.C. provides:

§ 4241. Determination of mental competency to stand trial

(a) MOTION TO DETERMINE COMPETENCY OF DEFENDANT.—At any time after the commencement of a prosecution for an offense and prior to the sentencing of the defendant, the defendant or the attorney for the Government may file a motion for a hearing to determine the mental competency of the defendant. The court shall grant the motion, or shall order such a hearing on its own motion, if there is reasonable cause to believe that the defendant may presently be suffering from a mental disease or defect rendering him mentally incompetent to the extent that he is unable to understand the nature and consequences of the proceedings against him or to assist properly in his defense.

(b) PSYCHIATRIC OR PSYCHOLOGICAL EXAMINATION AND REPORT.—Prior to the date of the hearing, the court may order that a psychiatric or psychological examination of the defendant be conducted, and that a psychiatric or psychological report be filed with the court, pursuant to the provisions of section 4247 (b) and (c).

(c) HEARING.—The hearing shall be conducted pursuant to the provisions of section 4247(d).

(d) DETERMINATION AND DISPOSITION.—If, after the hearing, the court finds by a preponderance of the evidence that the defendant is presently suffering from a mental disease or defect rendering him mentally incompetent to the extent that he is unable to understand the nature and consequences of the proceedings against him or to assist properly in his defense, the court shall commit the defendant to the custody of the Attorney General. The Attorney General shall hospitalize the defendant for treatment in a suitable facility—

(1) for such a reasonable period of time, not to exceed four months, as is necessary to determine whether there is a substantial probability that in the foreseeable future he will attain the capacity to permit the trial to proceed; and

(2) for an additional reasonable period of time until—

(A) his mental condition is so improved that trial may proceed, if the court finds that there is a substantial probability that within such additional period of time he will attain the capacity to permit the trial to proceed; or

(B) the pending charges against him are disposed of according to law;

whichever is earlier.

If, at the end of the time period specified, it is determined that the defendant's mental condition has not so improved as to permit the trial to proceed, the defendant is subject to the provisions of section 4246.

(e) DISCHARGE.—When the director of the facility in which a defendant is hospitalized pursuant to subsection (d) determines that the defendant has recovered to such an extent that he is able to understand the nature and consequences of the proceedings against him and to assist properly in his defense, he shall promptly file a certificate to that effect with the clerk of the court that ordered the commitment. The clerk shall send a copy of the certificate to the defendant's counsel and to the attorney for the Government. The court shall hold a hearing, conducted pursuant to the provisions of section 4247(d), to determine the competency of the defendant. If, after the hearing, the court finds by a preponderance of the evidence that the defendant has recovered to such an extent that he is able to understand the nature and consequences of the proceedings against him and to assist properly in his defense, the court shall order his immediate discharge from the facility in which he is hospitalized and shall set the date for trial. Upon discharge, the defendant is subject to the provisions of chapter 207.

(f) ADMISSIBILITY OF FINDING OF COMPETENCY.—A finding by the court that the defendant is mentally competent to stand trial shall not prejudice the defendant in raising the issue of his insanity as a defense to the offense charged, and shall not be admissible as evidence in a trial for the offense charged.

5. Section 4246 of Title 18, U.S.C., provides:

§ 4246. Hospitalization of a person due for release but suffering from mental disease or defect

(a) INSTITUTION OF PROCEEDING.—If the director of a facility in which a person is hospitalized certifies that a person in the custody of the Bureau of Prisons whose sentence is about to expire, or who has been committed to the custody of the Attorney General pursuant to section 4241(d), or against whom all criminal charges have been dismissed solely for reasons related to the mental condition of the person, is presently suffering from a mental disease or defect as a result of which his release would create a substantial risk of bodily injury to another person or serious damage to property of another, and that suitable arrangements for State custody and care of the person are not available, he shall transmit the certificate to the clerk of the court for the district in which the person is confined. The clerk shall send a copy of the certificate to the person, and to the attorney for the Government, and, if the person was committed pursuant to section 4241(d), to the clerk of the court that ordered the commitment. The court shall order a hearing to determine whether the person is presently suffering from a mental disease or defect as a result of which his release would create a substantial risk of bodily injury to another person or serious damage to property of another. A certificate filed under this subsection shall stay the release of the person pending completion of procedures contained in this section.

(b) PSYCHIATRIC OR PSYCHOLOGICAL EXAMINATION AND REPORT.—Prior to the date of the hearing, the court may order that a psychiatric or psychological examination of the defendant be conducted, and that a psychiatric or psychological report be filed with the court, pursuant to the provisions of section 4247(b) and (c).

(c) HEARING.—The hearing shall be conducted pursuant to the provisions of section 4247(d).

(d) DETERMINATION AND DISPOSITION.—If, after the hearing, the court finds by clear and convincing evidence that the person is presently suffering from a mental disease or defect as a result of which his release would create a substantial risk of bodily injury to another person or serious damage to property of another, the court shall commit the person to the custody of the Attorney General. The Attorney General shall release the person to the appropriate official of the State in which the person is domiciled or was tried if such State will assume responsibility for his custody, care, and treatment. The Attorney General shall make all reasonable efforts to cause such a State to assume such responsibility. If, notwithstanding such efforts, neither such State will assume such responsibility, the Attorney General shall hospitalize the person for treatment in a suitable facility, until—

(1) such a State will assume such responsibility; or

(2) the person's mental condition is such that his release, or his conditional release under a prescribed regimen of medical, psychiatric, or psychological care or treatment would not create a substantial risk of bodily injury to another person or serious damage to property of another;

whichever is earlier. The Attorney General shall continue periodically to exert all reasonable efforts to cause such a State to assume such responsibility for the person's custody, care, and treatment.

(e) DISCHARGE.—When the director of the facility in which a person is hospitalized pursuant to subsection (d) determines that the person has recovered from his mental disease or defect to such an extent that his release would no

longer create a substantial risk of bodily injury to another person or serious damage to property of another, he shall promptly file a certificate to that effect with the clerk of the court that ordered the commitment. The clerk shall send a copy of the certificate to the person's counsel and to the attorney for the Government. The court shall order the discharge of the person or, on the motion of the attorney for the Government or on its own motion, shall hold a hearing, conducted pursuant to the provisions of section 4247(d), to determine whether he should be released. If, after the hearing, the court finds by a preponderance of the evidence that the person has recovered from his mental disease or defect to such an extent that–

(1) his release would no longer create a substantial risk of bodily injury to another person or serious damage to property of another, the court shall order that he be immediately discharged; or

(2) his conditional release under a prescribed regimen of medical, psychiatric, or psychological care or treatment would no longer create a substantial risk of bodily injury to another person or serious damage to property of another, the court shall—

(A) order that he be conditionally discharged under a prescribed regimen of medical, psychiatric, or psychological care or treatment that has been prepared for him, that has been certified to the court as appropriate by the director of the facility in which he is committed, and that has been found by the court to be appropriate; and

(B) order, as an explicit condition of release, that he comply with the prescribed regimen of medical, psychiatric, or psychological care or treatment.

The court at any time may, after a hearing employing the same criteria, modify or eliminate the regimen of medical, psychiatric, or psychological care or treatment.

(f) REVOCATION OF CONDITIONAL DISCHARGE.—The director of a medical facility responsible for administering a regimen imposed on a person conditionally discharged under subsection (e) shall notify the Attorney General and the court having jurisdiction over the person of any failure of the person to comply with the regimen. Upon such notice, or upon other probable cause to believe that the person has failed to comply with the prescribed regimen of medical, psychiatric, or psychological care or treatment, the person may be arrested, and, upon arrest, shall be taken without unnecessary delay before the court having jurisdiction over him. The court shall, after a hearing, determine whether the person should be remanded to a suitable facility on the ground that, in light of his failure to comply with the prescribed regimen of medical, psychiatric, or psychological care or treatment, his continued release would create a substantial risk of bodily injury to another person or serious damage to property of another.

(g) RELEASE TO STATE OF CERTAIN OTHER PERSONS.—If the director of a facility in which a person is hospitalized pursuant to this chapter certifies to the Attorney General that a person, against whom all charges have been dismissed for reasons not related to the mental condition of the person, is presently suffering from a mental disease or defect as a result of which his release would create a substantial risk of bodily injury to another person or serious damage to property of another, the Attorney General shall release the person to the appropriate official of the State in which the person is domiciled or was tried for the purpose of institution of State proceedings for civil commitment. If neither such State will assume such responsibil-

ity, the Attorney General shall release the person upon receipt of notice from the State that it will not assume such responsibility, but not later than ten days after certification by the director of the facility.

(h) DEFINITION.—As used in this chapter the term "State" includes the District of Columbia.

6. Section 4247 of Title 18, U.S.C., provides:

§ 4247. General provisions for chapter

(a) DEFINITIONS.—As used in this chapter—

(1) "rehabilitation program" includes—

(A) basic educational training that will assist the individual in understanding the society to which he will return and that will assist him in understanding the magnitude of his offense and its impact on society;

(B) vocational training that will assist the individual in contributing to, and in participating in, the society to which he will return;

(C) drug, alcohol, and other treatment programs that will assist the individual in overcoming his psychological or physical dependence; and

(D) organized physical sports and recreation programs;

(2) "suitable facility" means a facility that is suitable to provide care or treatment given the nature of the offense and the characteristics of the defendant; and

(3) "State" includes the District of Columbia.

(b) PSYCHIATRIC OR PSYCHOLOGICAL EXAMINATION.—A psychiatric or psychological examination ordered pursuant to this chapter shall be conducted by a

licensed or certified psychiatrist or psychologist, or, if the court finds it appropriate, by more than one such examiner. Each examiner shall be designated by the court, except that if the examination is ordered under section 4245 or 4246, upon the request of the defendant an additional examiner may be selected by the defendant. For the purposes of an examination pursuant to an order under section 4241, 4244, or 4245, the court may commit the person to be examined for a reasonable period, but not to exceed thirty days, and under section 4242, 4243, or 4246, for a reasonable period, but not to exceed forty-five days, to the custody of the Attorney General for placement in a suitable facility. Unless impracticable, the psychiatric or psychological examination shall be conducted in the suitable facility closest to the court. The director of the facility may apply for a reasonable extension, but not to exceed fifteen days under section 4241, 4244, or 4245, and not to exceed thirty days under section 4242, 4243, or 4246, upon a showing of good cause that the additional time is necessary to observe and evaluate the defendant.

(c) PSYCHIATRIC OR PSYCHOLOGICAL REPORTS.—A psychiatric or psychological report ordered pursuant to this chapter shall be prepared by the examiner designated to conduct the psychiatric or psychological examination, shall be filed with the court with copies provided to the counsel for the person examined and to the attorney for the Government, and shall include—

(1) the person's history and present symptoms;

(2) a description of the psychiatric, psychological, and medical tests that were employed and their results;

(3) the examiner's findings; and

(4) the examiner's opinions as to diagnosis, prognosis, and—

(A) if the examination is ordered under section 4241, whether the person is suffering from a mental disease or defect rendering him mentally incompetent to the extent that he is unable to understand the nature and consequences of the proceedings against him or to assist properly in his defense;

(B) if the examination is ordered under section 4242, whether the person was insane at the time of the offense charged;

(C) if the examination is ordered under section 4243 or 4246, whether the person is suffering from a mental disease or defect as a result of which his release would create a substantial risk of bodily injury to another person or serious damage to property of another;

(D) if the examination is ordered under section 4244 or 4245, whether the person is suffering from a mental disease or defect as a result of which he is in need of custody for care or treatment in a suitable facility; or

(E) if the examination is ordered as a part of a presentence investigation, any recommendation the examiner may have as to how the mental condition of the defendant should affect the sentence.

(d) HEARING.—At a hearing ordered pursuant to this chapter the person whose mental condition is the subject of the hearing shall be represented by counsel and, if he is financially unable to obtain adequate representation, counsel shall be appointed for him pursuant to section 3006A. The person shall be afforded an opportunity to testify, to present evidence, to subpoena witnesses on his behalf, and to confront and cross-examine witnesses who appear at the hearing.

(e) PERIODIC REPORT AND INFORMATION REQUIREMENTS. —(1) The director of the facility in which a person is hospitalized pursuant to—

(A) section 4241 shall prepare semiannual reports; or

(B) section 4243, 4244, 4245, or 4246 shall prepare annual reports concerning the mental condition of the person and containing recommendations concerning the need for his continued hospitalization. The reports shall be submitted to the court that ordered the person's commitment to the facility and copies of the reports shall be submitted to such other persons as the court may direct. A copy of each such report concerning a person hospitalized after the beginning of a prosecution of that person for violation of section 871, 879, or 1751 of this title shall be submitted to the Director of the United States Secret Service. Except with the prior approval of the court, the Secret Service shall not use or disclose the information in these copies for any purpose other than carrying out protective duties under section 3056(a) of this title.

(2) The director of the facility in which a person is hospitalized pursuant to section 4241, 4243, 4244, 4245, or 4246 shall inform such person of any rehabilitation programs that are available for persons hospitalized in that facility.

(f) VIDEOTAPE RECORD.—Upon written request of defense counsel, the court may order a videotape record made of the defendant's testimony or interview upon which the periodic report is based pursuant to subsection (e). Such videotape record shall be submitted to the court along with the periodic report.

(g) HABEAS CORPUS UNIMPAIRED.—Nothing contained in section 4243 or 4246 precludes a person who is committed under either of such sections from establishing by writ of habeas corpus the illegality of his detention.

(h) DISCHARGE.—Regardless of whether the director of the facility in which a person is hospitalized has filed a certificate pursuant to the provisions of subsection (e) of section 4241, 4244, 4245, or 4246, or subsection (f) of section 4243, counsel for the person or his legal guardian may, at any time during such person's hospitalization, file with the court that ordered the commitment a motion for a hearing to determine whether the person should be discharged from such facility, but no such motion may be filed within one hundred and eighty days of a court determination that the person should continue to be hospitalized. A copy of the motion shall be sent to the director of the facility in which the person is hospitalized and to the attorney for the Government.

(i) AUTHORITY AND RESPONSIBILITY OF THE ATTORNEY GENERAL.—The Attorney General–

(A) may contract with a State, a political subdivision, a locality, or a private agency for the confinement, hospitalization, care, or treatment of, or the provision of services to, a person committed to his custody pursuant to this chapter;

(B) may apply for the civil commitment, pursuant to State law, of a person committed to his custody pursuant to section 4243 or 4246;

(C) shall, before placing a person in a facility pursuant to the provisions of section 4241, 4243, 4244, 4245, or 4246, consider the suitability of the facility's rehabilitation programs in meeting the needs of the person; and

(D) shall consult with the Secretary of the Department of Health and Human Services in the general implementation of the provisions of this chapter and in the establishment of standards for facilities used in the implementation of this chapter.

(j) Sections 4241, 4242, 4243, and 4244 do not apply to a prosecution under an Act of Congress applicable exclusively to the District of Columbia or the Uniform Code of Military Justice.

7. Section 549.43 of Title 28 of the C.F.R. provides:

§ 549.43 Involuntary psychiatric treatment and medication.

Title 18 U.S.C. 4241-4247 and federal court decisions require that certain procedures be followed prior to the involuntary administration of psychiatric treatment and medication to persons in the custody of the Attorney General. Court commitment for hospitalization provides the judicial due process hearing, and no further judicial authorization is needed for the admission decision. However, in order to administer treatment or psychotropic medication on an involuntary basis, further administrative due process procedures, as specified in this section, must be provided to the inmate. Except as provided for in paragraph (b) of this section, the procedures outlined herein must be followed after a person is committed for hospitalization and prior to administering involuntary treatment, including medication.

(a) *Procedures:* When an inmate will not or cannot provide voluntary written informed consent for psychotropic medication, the inmate will be scheduled for an administrative hearing. Absent an emergency situation, the inmate will not be medicated prior to the hearing. In regard to the hearing, the inmate will be given the following procedural safeguards:

(1) Staff shall provide 24-hour advance written notice of the date, time, place, and purpose of the hearing, including the reasons for the medication proposal.

(2) Staff shall inform the inmate of the right to appear at the hearing, to present evidence, to have a staff representative, to request witnesses, and to request that witnesses be questioned by the staff representative or by the person conducting the hearing. If the inmate does not request a staff representative, or requests a staff representative with insufficient experience or education, the institution mental health division administrator shall appoint a staff representative. Witnesses should be called if they have information relevant to the inmate's mental condition and/or need for medication, and if they are reasonably available. Witnesses who only have repetitive information need not be called.

(3) The hearing is to be conducted by a psychiatrist who is not currently involved in the diagnosis or treatment of the inmate.

(4) The treating/evaluating psychiatrist/clinician must be present at the hearing and must present clinical data and background information relative to the need for medication. Members of the treating/evaluating team may also attend the hearing.

(5) The psychiatrist conducting the hearing shall determine whether treatment or psychotropic medication is necessary in order to attempt to make the inmate competent for trial or is necessary because the inmate is dangerous to self or others, is gravely disabled, or is unable to function in the open population of a mental health referral center or a regular prison. The psychiatrist shall prepare a written report regarding the decision.

(6) The inmate shall be given a copy of the report and shall be advised that he or she may submit an appeal to the institution mental health division administrator

regarding the decision within 24 hours of the decision and that the administrator shall review the decision within 24 hours of the inmate's appeal. The administrator shall ensure that the inmate received all necessary procedural protections and that the justification for involuntary treatment or medication is appropriate. Upon request of the inmate, the staff representative shall assist the inmate in preparing and submitting the appeal.

(7) If the inmate appeals, absent a psychiatric emergency, medication will not be administered before the administrator's decision. The inmate's appeal, which may be handwritten, must be filed within 24 hours of the inmate's receipt of the decision.

(8) A psychiatrist, other than the attending psychiatrist, shall provide follow-up monitoring of the patient's treatment or medication at least once every 30 days after the hearing. The follow-up shall be documented in the medical record.

(b) *Emergencies*: For purpose of this subpart, a psychiatric emergency is defined as one in which a person is suffering from a mental illness which creates an immediate threat of bodily harm to self or others, serious destruction of property, or extreme deterioration of functioning secondary to psychiatric illness. During a psychiatric emergency, psychotropic medication may be administered when the medication constitutes an appropriate treatment for the mental illness and less restrictive alternatives (e.g., seclusion or physical restraint) are not available or indicated, or would not be effective.

(c) *Exceptions*: Title 18 United States Code, sections 4241 through 4247 do not apply to military prisoners, unsentenced Immigration and Naturalization Service (INS)

detainees, unsentenced prisoners in Bureau custody as a result of a court order (e.g. a civil contemnor), state or territorial prisoners, and District of Columbia Code offenders. For those persons not covered by sections 4241-4247, the decision to involuntarily admit the person to the hospital must be made at an administrative hearing meeting the requirements of Vitek v. Jones. The decision to provide involuntary treatment, including medication, shall nonetheless be made at an administrative hearing in compliance with § 549.43.